

Original Research Article

Perceptions on adolescents' friendly health services concepts and the use of health services by adolescents in Kavango region, Namibia

Taimi Amakali-Nauseb^{1*}, Joan M. Kloppers²

¹Department of Community and Mental Health Science, School of Nursing, University of Namibia, Windhoek, Namibia

²School of Nursing, International University of Management, Namibia

Received: 19 December 2020

Revised: 17 February 2021

Accepted: 19 February 2021

***Correspondence:**

Dr. Taimi Amakali-Nauseb,

E-mail: tnauseb@unam.na

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ABSTRACT

Background: The objective of this study was to determine the perceptions on adolescents' friendly health services concepts and the use of health services by adolescents in Kavango region, Namibia.

Methods: A cross-sectional analytical study was conducted using mixed methods - quantitative and qualitative approaches among 350 school learners and 150 school drop-out adolescents. In total a sample of 540 was utilized. The stratified random sampling techniques were used in the selections of the circuit and the schools. Structured questionnaires were used in face-to-face interviews, and in depth interviews were conducted among the key informants (25 teachers) and as well with 15 school learners.

Results: Illustrated the following: there was a statistically highly significant association between adequate confidentiality, last visit at the health facility and both sexually transmitted infections and visited health facility ($p=0.004$ respectively). A statistically significant association was found between all visits to health facilities, pamphlets and talks on contraceptives; visit to health facilities, comfortable and contraceptives talks ($p=0.001$ respectively). Additionally, there was a statistically significant association respectively between both contraceptives used and number of times services sought and between services, pamphlets and contraceptives with a ($p 0.010 < 0.05$).

Conclusions: The youth need health services that are sensitive to their unique stage of biological, cognitive, and psychosocial transition into adulthood. Health services that are more accessible and acceptable to adolescents and made more youth-friendly.

Keywords: Adolescents, Contraceptives, Family planning methods, Reproductive health, Sexual health

INTRODUCTION

The objective of this study was to determine the perceptions on adolescents' friendly health services concepts and the use of health services by adolescents in Kavango region, Namibia.

This article was extracted from the authors study "a model for reproductive health and pregnancy preventing

strategies among adolescents in schools in Kavango region, Namibia.

Adolescent pregnancy appears unwanted because it is unplanned. This is substantiated by the study on teenage pregnancy by the United States Agency for International Development (USAID) in Namibia the findings of which has proven that 91% of pregnancies among adolescents in Kavango region of Namibia were unwanted.¹

Unplanned adolescent pregnancy is often terminated by abortion, a negative experience that may have a lifelong emotional and social impact on the woman. Namibia is no exception to the problem of adolescent pregnancy. Both the report of MoHSS, Namibia Demographic Health Survey and USAID indicated that the rate of teenage pregnancy in Namibia stands at 15.4% and 15% respectively.^{1,2}

Although different regions of Namibia are affected, Kavango region in Northern Namibia is mostly affected by the problem of teenage pregnancy. According to the USAID report, the region has the highest rate of 34% teenage pregnancy among 15 to 19 year olds. A report from a local study indicated that a number of risk factors have been linked to teenage pregnancy.³ These include early sexual activities and poor use of contraceptives, poverty or low socio-economic status, poor school performance and low self-esteem or depression.

Furthermore, the USAID report on teenage pregnancy in Kavango region indicated that lack of access to family planning as a result of the traditional orientation of family planning in favor of older and married women by health care providers is partly responsible for teenage pregnancy in the region.¹ Additionally, the USAID report adds that ignorance among the adolescent girls is also to blame for teenage pregnancy.¹ The report indicated that while 98% of young people were informed about contraceptives, only 8.7% of them use it. This claim is also substantiated by a report compiled by United Nations Children’s Fund (UNICEF), which indicates that adolescent girls in Namibia have low levels of contraceptive use and, only above 61% of condom use.⁴

The United Nations Population Fund (UNFPA) released these statistics in commemoration of the World Population Day, celebrated on the 11 July 2016, every year. In the year 2016 the theme was “Investing in Teenage Girls”. When the statistics were compiled, there were 245 431 adolescents girls population in Namibia aged between 15 and 19.46 000 adolescent fell pregnant, 66% of the population under the age of 19, 39% below the age of 15.⁵

METHODS

Study design

A cross-sectional analytical study was conducted using mixed methods - quantitative and qualitative approaches among 350 school learners (grade 6 to grade 12) and 150 school drop-out adolescents. In total a sample of 540 was utilized. The stratified random sampling techniques were used in the selections of the circuit and the schools. Structured questionnaires were used and face-to-face in depth interviews, were conducted among the key informants (teachers). For the qualitative approaches 15 school learners and 25 teachers went through an in-depth interview.

Study place

The study area was public primary and as well secondary schools in Kavango region.

Study period

The study was conducted for the period of three months i.e. March 2016 to May 2016.

Study population

The study population groups were in threefold, the school learners in primary or secondary school, the teachers at different schools and the adolescent’s in the community who had dropped out of school.

Target population

The first target population were the school learners falling within the age group of between 12- 19 years. The second target population were teachers at different schools teaching life science, life skills, biology or natural science. The third target populations were the adolescent’s in the communities who had dropped out and or never went to school and falls within the age group of between 12-19 years.

Sample size

A sample size of 500 adolescents was determined using Epi-info version 7 considering at least 95% significance level for the quantitative aspects. For the qualitative aspects, an additional sample of 15 adolescents and 25 teachers undertook an in-depth interview. In total a sample of 540 adolescents were utilized, 515 adolescents and 25 teachers.

Sampling criteria

The inclusion criteria and exclusion criteria for school learners were indicated below.

Table 1: The inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
Adolescents, 12-19 years	Adolescents below 12 years and above 19 years
School goers	Out of school
Willingness to participate	Not willing to participate
Good understanding and comfortable with English language	Not understanding and not comfortable with English language
Agree to answer general health questions related to risky behaviours.	Does not agree to answer general health questions related to risky behaviours.

Data collection

Preparing the field

For both the schools and the community: Prior telephonic arrangements were made with the school principals and councilors regarding the purposes of the visit, date and time for the visits to Kavango Region and to the specific schools.

Procedure at schools

The researcher reported to the principal's office whereby the researcher submitted all written proof of letters for permission as obtained from the different institutions. Data collection took place in laboratory classroom or life skills, whereby the teacher responsible for life science, life skills, natural science or biology accompanied the researcher. At some instances the learners waited at the mentioned classrooms and at other school's learners were called for the data collection once the researcher turned up.

The researcher was provided in advance with the class list of the specific grades, and carried out simple random selection. After explaining the purpose and objectives of the study and obtaining permission from the learners, the researcher distributed the questionnaires to each learner. The questionnaires were in English and consisted out of open-ended close questions. The questionnaire's consisted out of five subsections which were as follows: demographic data; sexual and reproductive health characteristics, potential risk factors, family planning and social background.

Procedure in the community

The constituencies were visited on different days. The researcher reported at the constituencies' office and the representative of the councilor was waiting as prior arranged.

Data analysis

Descriptive statistics was employed to summarise the above mentioned variables. Cross-tabulations of adolescents' friendly health services (ADFHS) variables were used to describe the relative frequencies. The associations between different categorical variables were assessed using Chi-square test whilst the identification of different determining factors was analyzed with the epidemiological methods using odds ratios and/or estimated relative risks.

The means, standard deviation and 95 % confidence interval were computed. The differences between different variables or factors were considered to be statistically significant for $p < 0.05$. The Odds Ratios, 95% confidence intervals, was used to estimate the relative risk and p-values were computed.

A p-value of less than 0.05 was considered statistically significant and statistical package for social sciences (SPSS) software version 23 was used in all analyses. The data was presented as tables and graphs. Categorical variables were compared using a Pearson chi-square test.

RESULTS

Demographic information

Age

Mean age of the participants was 16 years and the age range was between 12-19 years.

Sex

Total 40% (6) of the participants were males and 60% (9) were females.

Table 2: Perception and use of ADFHS characteristics- association between adequate confidentiality and last visit at the health facility.

		Confidentiality		Total	P value
		Yes	No		
Last visit	Government	194	161	355	0.004
	Private	29	45	74	
	Other	46	23	69	
Total		269	229	498	
Last visit	Government	211	146	357	0.013
	Private	32	42	74	
	Other	32	37	69	
Total		275	225	500	
Last visit	Government	181	176	357	0.022
	Private	28	46	74	
	Other	25	44	69	
Total		234	266	500	

* P-value statistically significant at the level of significant 0.05

Table 3: Perception and use of ADFHS characteristics -association between talk attended on sexually transmitted diseases and visited health facility.

		STD		Total	P value
		Yes	No		
Visited health facility	Yes	138	53	191	0.002
	No	128	98	226	
	Not applicable	59	24	83	
Total		325	175	500	

* P-value statistically significant at the level of significant 0.05

Table 4: Perception and use of ADFHS characteristics- association between visit of health facility, confidentiality and talk contraceptive.

Confidentiality			Talk contraceptives		Total	P value
			Yes	No		
Yes	Visit HF	Yes	78	46	124	0.001
		No	48	42	90	
		Not applicable	38	17	55	
	Total	164	105	269		
No	Visit HF	Yes	32	35	67	0.001
		No	47	88	135	
		Not applicable	12	15	27	
	Total	91	138	229		
Total	Visit HF	Yes	110	81	191	0.001
		No	95	130	225	
		Not applicable	50	32	82	
	Total	255	243	498		

* P value statistically significant at the level of significant 0.05

Table 5: Perception and use of ADFHS characteristics- association between contraceptives used and number of times service sought.

			Contraceptives		Total	P value
			Yes	No		
Services	Number of times		137	62	199	0.010
	Did not seek care in 12 months		40	40	80	
	Not applicable		133	88	221	
Total			310	190	500	
Pamphlets						
Yes	Services	Number of times	92	9	101	0.010
		Did not seek care in 12 months	22	16	38	
		Not applicable	74	21	95	
Total			188	46	234	
No	Services	Number of times	45	53	98	0.010
		Did not seek care in 12 months	18	24	42	
		Not applicable	59	67	126	
Total			122	144	266	
Total	Services	Number of times	137	62	199	0.010
		Did not seek care in 12 months	40	40	80	
		Not applicable	133	88	221	
Total			310	190	500	

* P value statistically significant at the level of significant 0.05.

Grade

The grades of the participants were as follows: 53.3% (8) for Grade 11; 26.7% (4) for Grade 9 and 20% (3) Grade 8.

Living

Total 46.7% (7) live with both parents, 20% (3) live in the hostel, 13.3% (2) live with their father; 6.7% (1) live both mother and the aunt, and as well with the grandmother.

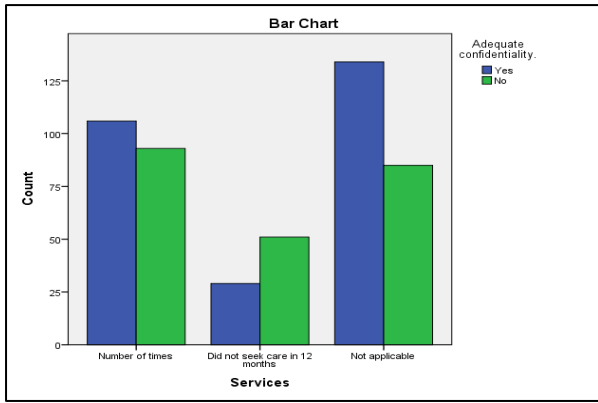


Figure 1: Association between adequate confidentiality and number of times services sought.

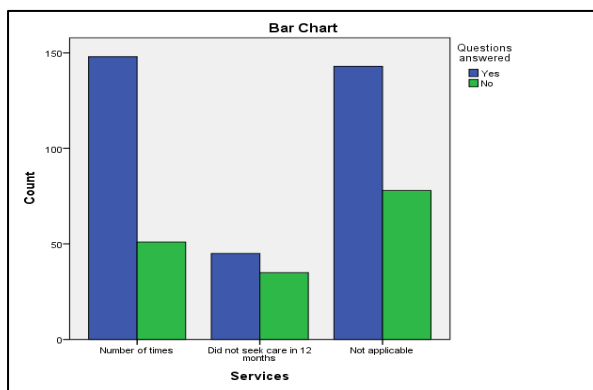


Figure 2: Association between questions answered adequately and number of times services sought.

Knowledge and perceptions about adolescent health-care services

Health facility which was visited

Total 80% (12) of the participants visited a public clinic and 6.7% (1) visited the hospital, 6.7% (1) visited private doctors and 6.7% (1) private clinics respectively.

Most of the participants prefer to visit public clinics. They are not so expensive as the private doctors and the private clinics. With the private doctors one needs to make an appointment and must have a medical fund which most of the parents don't have. Participants can visit public facilities any time with no appointment (Table 2).

Adolescents visited the health facility for the following type of services

Stomach pain; headache and flu; monthly check-up for tonsils; eye test; stitching of wounds; asthma treatment; sonar; doctor's appointment; full body check-up and family planning. Activities of health services include identification of health problems, treatment of common ailments and injuries, referrals, growth monitoring, checkups, monitoring of outbreaks, vaccinations and referrals for appropriate treatment (Table 3, 4).⁶

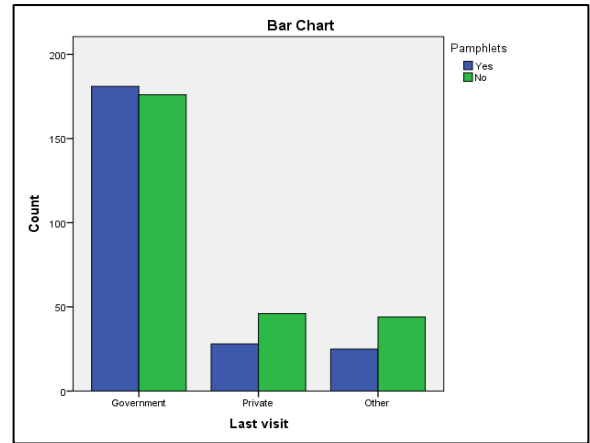


Figure 3: Association between pamphlets given and last visit at the health facility.

Health-care services

Total 100% (15) of the participants pointed out that they received services accordingly.

Informational materials for adolescents, including video or TV, observed in the waiting area

Total 53.3% (8) stated yes while 46.7% (7) stated that were no information about adolescents, but there was television available. A lack of comprehensive education in schools, homes or youth centers may mean that adolescents do not acquire the necessary information (Figure 3) (Table 4).⁷

Displayed services as provided for the adolescents

Here, 33.3% (5) responded yes while 66.7% (10) stated no, but there were just some of health, cars and insurance magazines. The Namibian Ministry of Health has a program of Adolescent friendly services, which is being implemented, in six regions of Namibia to improve health services for the adolescents.

Welcome and safe at the health facility

Total 86.7% (13) responded that yes they felt welcomed, while 6.7% (1) pointed out that somehow they felt welcomed and felt at home respectively. Health workers received training in adolescent friendly health services and were given points accordingly. The clinic staff, administration staff and cleaners all need to be friendly towards adolescents (Figure 2).⁶

DISCUSSION

Physical environment

Some adolescents saw the environment clean with a good smell while others are negative that the environment is dirty and does not smell hygienic and fresh.

Attitude

Most of the time the public complain about the health worker's attitude. One read about it in the newspapers or heard it over the radio. The adolescents commented positively on the health professional's attitude.

Health consequences of getting married at a young age

The adolescents knew the health consequences of getting married early. The adolescents mentioned the following aspects: no support; risk of getting infected; dropping out of school; premature death; stress; suicide; financial problems and death. According to the UNFPA delay of child bearing to experience maternal illness, miscarriage, stillbirth and neonatal death. Babies of teenage mothers are born with low birth weight and experience health development problems. Adolescent pregnancies can lead to financial burden to society.⁵

Contraception methods

Contraceptives also called birth control are usually used to prevent pregnancies. Many young people are sexually active and need to have more information regarding the different contraceptive methods that is available to them. Counseling dialogues between the adolescent and members of the health-care team should be structured in making a decision that is informed, voluntary and appropriate to the adolescent's.⁷ Adolescents may also be less likely to possess the motivation and skill to use a contraceptive method correctly. Even when adolescents have correct information about contraceptives, this will not guarantee that responsible sexual behavior will follow.^{7,9}

Waiting time

The waiting time at health facilities is long due to staff shortage. Health workers are looking for greener pastures and financial freedom. The consequences of stigma and discrimination are wide-ranging. Families, peers and the wider community shunned some people while others face poor treatment in healthcare and education settings, erosion of their human rights and psychological damage.¹⁰

The respondents waiting time was as follows: 2–3 hours=13.3% (2); 30 minutes-1 hour=33.3% (5); 5-30 minutes =53.3% (8).

Involvement of adolescent's quality healthcare

Most of the time adolescents are neglected, because health workers see them as healthy people. In Namibia the Ministry of Health and Social Services started with the Adolescent Friendly health services to enable the adolescents to receive excellent health services. Previous experiences with health care workers or with health-care delivery sites are likely to influence the use of contraceptives services when the need arises.^{7,10}

Physical environment

Some adolescents see the environment clean with a good smell while others are negative that the environment is dirty and does not smell hygienic.

CONCLUSION

The youth need health services that are sensitive to their unique stage of biological, cognitive, and psychosocial transition into adulthood. Health services that are more accessible and acceptable to adolescents and made more youth-friendly.

ACKNOWLEDGEMENTS

This research project would not have been possible without the support of many people. I wish to express my gratitude to the professional colleagues, who have been abundantly helpful and offered invaluable assistance and guidance. I also want to thank my friends for their assistance. MBEC for granting me permission and all the learners and teachers in Khomas Region who agreed to participate in my pilot study; and all the learners and teachers who agreed to participate in the study, in Kavango Region.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee

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Cite this article as: Amakali-Nauseb T, Kloppers JM. Perceptions on adolescents' friendly health services concepts and the use of health services by adolescents in Kavango region, Namibia. *Int J Community Med Public Health* 2021;8:1632-8.